STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S SENIOR LIVING COMMUNITY	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00151847. Complaint IN00151847-Substantiated. No deficiencies related to the allegations are cited. Survey Dates: July 23, 24, 25, 28, 29, 30, & 31, 2014 Facility number: 000171 Provider number: 155271 AIM number: 100267050 Survey Team: Beth Walsh, RN-TC Karina Gates, Generalist Tom Stauss, RN Census Bed Type: SNF: 7 SNF/NF: 69 Total: 76 Census Payor Type: Medicare: 13 Medicaid: 59 Other: 4 Total: 76	F000000	Please accept this 2567 Plan of Correction for the Health Survey ending July 31st, 2014 as the Provider's Letter of Credible Allegation. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correction with a completion date of August 30th, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 11, 2014 by Cheryl Fielden, RN.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in			

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	§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the Physician about a fall in timely manner for 1 of 5 residents reviewed for falls and missed antibiotic doses for 1 of 6 residents reviewed for unnecessary medications. (Residents #4 and #114) Findings include: 1. The clinical record for Resident #4 was reviewed 07/29/14 at 2:15 p.m. The diagnoses for Resident #4 included, but were not limited to, diabetes mellitus, hypothyroidism, and depression.. A review of an Occurrence Initial Assessment, dated 7/15/14 at 9:27 p.m., indicated Resident #4 had fall on 7/15/14 at 9:15 p.m. The Assessment did not indicate the Physician was notified of the fall, at the time of fall or shortly after the fall. An Occurrence Follow-Up Assessment, dated 7/15/14 at 9:47 p.m., indicated a small red cut 1.0 cm (centimeter) in	F000157	**F 157 NOTIFY OF CHANGES (INJURIES/DECLINE/ROOM, ETC)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #4 – MD was notified of resident fall on 7/16/14 and resident #4 no longer resides in facility · Resident #114 -- MD and resident were notified on 8/21/14 that three doses were missed. Resident #114 suffered no ill effects from missed doses **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents at risk for falls or are on antibiotic therapy have the potential to be affected by the alleged deficient practice · Residents who have had a	08/30/2014

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	diameter on right eyebrow. The Assessment also indicated a small amount of blood at the site and the cut was cleansed with normal saline and a bandage was placed. The Assessment did not indicate the Physician was notified of the fall. The Clinical Record did not indicate the Physician was notified about the fall until the next day, on 7/16/14 at 1:03 p.m. A review of a policy, titled Physician and Family Notification of Condition Changes, dated 3/1/03, was received from the QA Nurse on 7/28/14 at 1:30 p.m. The policy indicated, "...b. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan...." A review of a policy titled, First Aid-Falls, dated 3/12, was received from the DoN on 7/29/14 at 12:20 p.m. The policy indicated, "...h. Assess for injury to head. If noted [sic] begin neuro checks immediately. If head injury is severe or neuro check is abnormal, leave resident on floor until physician is consulted...." The policy did not indicate to notify the physician at any other time when there was a Resident fall. During an interview with the		fall within the last 30 days will be audited to ensure MD has been notified appropriately · Residents who have had an order for antibiotic therapy within the last 30 days will be audited to ensure doses have been administered as ordered · Licensed Nurses will be in-serviced on Physician & Family Notification of Condition Changes and Emergency Pharmacy Service and Emergency Kits by the Director of Nursing or designee by August 30th, 2014 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed Nurses will be in-serviced on Physician & Family Notification of Condition Changes and Emergency Pharmacy Service and Emergency Kits by the Director of Nursing or designee by August 30th, 2014 · Condition changes specific to falls and MD notification will be monitored daily by nurse management or designee reviewing progress notes and 24 hour report to ensure MD notified timely · Residents currently on antibiotic therapy will be	

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	Administrator, on 7/30/14 at 9:40 a.m., the Administrator indicated the facility was unable to locate any documentation the Physician was notified prior to the day after the fall. On 7/30/14 at 11:15 a.m., the Director of Nursing (DoN) indicated the Physician was supposed to notified of a Resident's fall right away, especially if there was evidence the Resident fell on their head. During an interview with the DoN, on 7/31/14 at 10:25 a.m., the DoN indicated the Physician should be notified any time there was a fall. The DoN also indicated notifying the Physician, after a fall, was a professional nursing standard. The DoN further indicated the First Aid-Fall policy probably needed to be revised to include notifying the Physician anytime there was a fall and not just with a severe head injury. On 7/31/14, at 10:30 a.m., the Quality Assurance (QA) Nurse indicated it was a professional nursing standard to notify the physician of a fall and the QA Nurse indicated she will let their Corporate Office know about possibly revising the First Aid-Fall policy. 2. The clinical record for Resident #114 was reviewed 07/25/14 at 1:40 p.m. The		monitored daily by nurse management or designee reviewing MAR/TAR to ensure doses are not missed and/or proper MD notification occurs **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Notification of Change QA tool will be utilized weekly X 4 weeks, monthly X 3 months, and quarterly thereafter to ensure timely and appropriate MD notification occurs ·Medication Availability QA tool will be utilized weekly X 4 weeks, monthly X 3 months, and quarterly thereafter to ensure medications are available as ordered ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	

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	diagnoses for Resident #114 included, but were not limited to, dementia without behavioral disturbances, depression, hepatitis, and congestive heart failure. A Physician's Order, dated 6/18/14, indicated an order for Cleocin (antibiotic) 300 mg (milligrams) by mouth three times a day at 6 a.m., 2 p.m., and 10 p.m. for 7 days for a suspected mandibular (jaw) abscess/infection. The June MAR (Medication Administration Record) indicated Cleocin was not given the following days: 6/19/14 at 10 p.m., 6/20/14 at 6 a.m., and 6/22/14 at 6 a.m. During an interview with the Quality Assurance (QA) Nurse, on 7/28/14 at 10:50 a.m., the QA Nurse indicated the Cleocin was not given on the dates and times listed above, according to the MAR. At 11:47 a.m., on 7/28/14, the QA Nurse indicated she was unable to locate any documentation that indicated the Physician was notified the antibiotic was not given as ordered and the QA Nurse further indicated the Physician should have notified about the missed doses of			

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	the antibiotic, since the antibiotic was not given as ordered. 3.1-5(a) 3.1-5(a)(1)			
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to honor a resident's/family's preference for waking up in the morning for 1 of 1 resident reviewed of 1 who met the criteria for choices. (Resident #154) Findings include: The clinical record for Resident #154 was reviewed on 7/24/14 at 2:00 p.m. The diagnoses for Resident #154 included, but were not limited to, history of stroke and altered mental status.	F000242	**F242 SELF-DETERMINATION – RIGHT TO MAKE CHOICES** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·The family of resident #154 was interviewed on 7/30/14 to obtain information regarding resident's prior routine and preferences. Care Plan and CNA assignment sheets were updated accordingly ·Resident #154 no longer resides in facility as of 8/19/14 **How will you identify other residents having the potential**	08/30/2014

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	A telephone interview was conducted with Resident #154's daughter, Family Member #5, on 7/24/14 at 2:49 p.m. Family Member #5 indicated she was very familiar with the way Resident #154 lived her life prior to her 7/4/14 admittance to the facility. Regarding whether Resident #154 got up in the morning according to her previous routine, she indicated, "No. She would normally get up around noon or 1:00 p.m., and now she gets up in time for breakfast." An interview was conducted with BNA (Basic Nurse Aide) #4 on 7/29/14 at 11:45 a.m. She indicated she worked the day shift, from 6:00 a.m. to 2:00 p.m., and worked with Resident #154 on that shift for the past week or 2. She indicated she and therapy woke Resident #154 up the morning of 7/29/14 about 7:00 a.m. She stated, "We had to wake her up. The night shift aide, (name of night shift aide), dressed her before I got here. I woke her up, because she was asleep in her bed. She's usually always sleeping when I get her up. I've worked this hall the last 2 weeks and I've always had to wake her up before breakfast. (Name of night shift aide) will dress her, and I'll rewake (sic) her up. If therapy doesn't request for her to get up, I'll wait		**to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice ·Facility Guardian Angel representatives will interview their assigned residents or families utilizing the 'Resident Preferences' questionnaire to evaluate for choice ·Once preferences are identified, appropriate departments will be notified and CNA assignment sheets and Care Plans will be updated accordingly to ensure resident choices are honored ·In-services will be conducted by August 30th, 2014 by the Director of Nursing and/or designee including Resident Rights and Resident Preferences **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·In-services will be conducted by August 30th, 2014 by the Director of Nursing and/or designee including Resident Rights and Resident Preferences ·Activity Director or designee will utilize the 'Resident Preferences' questionnaire for all new residents and notify the Interdisciplinary Team to update CNA assignment sheets	

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	'til 7:45 (a.m.), but that's the latest I'll get her up. That way, she doesn't miss breakfast, even though she's not eating breakfast. She hasn't eaten in the last week. (Name of Resident #154) does not like to get up, even at 7:45 (a.m.)" Regarding how she was aware Resident #154 did not like to get up at 7:45 a.m., she indicated, "She will start to whale, almost cry. We cant just leave her in bed, so we coax her into getting up, and eventually, she'll get up. Every resident can stay in bed until they want to. We get her up that early, so she doesn't miss breakfast." Regarding whether Resident #154 staying in bed and receiving a room tray for breakfast was an option, she indicated, "We've saved trays for her before, to try and get her to eat in her room, and she's still not eating. There's no difference in outcome as far as eating, whether she stays in her room or goes to the dining room. She still doesn't eat.... The daughter told me to try to get her up for breakfast, lunch and dinner, but if she absolutely doesn't want to, to save her a tray, and just let her be." Another telephone interview was conducted with Family Member #5 on 7/30/14 at 9:58 a.m. Regarding the conversation with BNA #4, she indicated, "She is used to getting up around noon. If she doesn't like it, let's not do it. It		accordingly ·Guardian Angel representative will follow up with residents and/or families monthly to ensure preferences are honored and the Interdisciplinary Team will update resident care sheets accordingly **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Resident Preferences QA tool will be completed by Activity Director or designee weekly x 4 weeks, monthly x 3 months, and quarterly for one year with results reported to the QA Committee overseen by the Executive Director Guardian Angel representatives will interview residents and/or families with QIS interview tool which includes preferences monthly and report findings in QA Committee	

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	doesn't surprise me that she doesn't like it. There's a lot of miscommunication. I have to say things multiple times to staff. We did the care plan meeting 3 days after her arrival. Honestly, I don't recall discussing her wake up time in that meeting. The fact that she's being woken twice, I'd like for that to change. The later, the better." An interview was conducted with LPN #6 on 7/30/14 at 10:12 a.m. She indicated, "I remember talking to her daughter about her preference for getting up. If I recall, she said they were not early risers." An interview was conducted with the DON (Director of Nursing) on 7/30/14 at 10:17 a.m. She indicated, the facility began waking up residents at 5:00 a.m. Regarding how the facility determines when to wake up a cognitively impaired resident. She indicated, "If there's no indication they don't want to get up at the usual start, like crying or agitated or fatigued, or if family doesn't indicate a preference on the care plan prior, we start getting up around 5 a.m." During this interview, a resident interview sheet for Resident #154 was provided by CNA #11 that indicated, "Breakfast/therapy" as the time to get up.			

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	Another interview was conducted with the DON on 7/30/14 at 1:31 a.m., after she spoke with Family Member #5 regarding Resident #154's wake up time. The DON indicated, "She was clear about not wanting her to get up at 6 a.m. by night shift. She said, if she's awake, to go ahead and offer breakfast. If she's not up, to leave her sleeping. She was steadfast about the "no 6 a.m." Regarding whether Resident #154's family was made aware of the time she would be woken up, the DON indicated, "I am not sure the family knew we would be getting her up as early as 6 (a.m.) I would have expected the CNA (BNA #4) to tell me the resident whaled or cried out in the morning. If I had known, and thought it was related to her getting up, we would not have got her up in the morning." On 7/31/14 at 10:32 a.m., the DON indicated, "I talked to therapy, and we decided to switch her therapy time to 11:00 a.m." 3.1-3(u)(3)			

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F000252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to ensure a footboard was replaced on the resident's bed. This affected 1 of 35 residents reviewed for homelike environments. (Resident #89) On 7/30/14 at 11:42 a.m., during an observation, Resident #89's bed footboard was observed to be broken in half with only one half of a footboard present on the resident's bed. During an interview with CNA #3 on 7/30/14 at 1:44 p.m., she indicated she informed Maintenance approximately "a month ago" about Resident #89's broken footboard. She indicated not knowing why it was still unrepaired. On 7/31/14 at 9:22 a.m., during an interview, the Administrator indicated the maintenance logs did not indicate maintenance staff was aware of the damaged footboard. 3.1-9(a)	F000252	**F252** **SAFE/CLEAN/COMFORTABLE/ HOMELIKE ENVIRONMENT** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Footboard on bed of Resident #89 was replaced immediately **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents who reside in facility and sleep in a bed have the potential to be affected by the alleged deficient practice ·Maintenance and/or designee will perform audit of all resident beds in facility to ensure all aspects of bed are in proper repair and good working order and correct any deficiencies found immediately ·Staff will be in-serviced by August 30th, 2014 by the Maintenance Director and/or designee on the Maintenance	08/30/2014

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			Repair Request Log and how to communicate items needing repaired **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·Staff will be in-serviced by August 30th, 2014 by the Maintenance Director and/or designee on the Maintenance Repair Request Log and how to communicate items needing repaired ·Maintenance Director or designee will monitor Maintenance Repair Log 5 X week to ensure compliance and follow up with items called in to on-call phone during non business hours **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Maintenance/Environmental QA tool will be utilized weekly X 4 weeks, monthly X 3 months, and quarterly thereafter to ensure resident furniture is in proper	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			repair and promotes a homelike environment ·Any deficiencies will be reported to the QA Committee overseen by the Executive Director	
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow Physician Orders for lab draws, drawing blood specimens, and administering antibiotics as ordered. This affected 2 of 6 residents reviewed for unnecessary medications (Resident #88 & #114) This facility also failed to ensure daily weights were obtained as ordered for 1 of 21 residents reviewed for following physician's orders. (Resident #154) Findings include: 1a. The clinical record for Resident #88 was reviewed 07/25/14 at 2:00 p.m. The diagnoses for Resident #88 included, but were not limited to, multiple sclerosis, diabetes mellitus, and dementia with behavioral disturbances. The July Physician's Orders indicated an	F000282	**F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #88 was approached on 7/30/14 and asked how he would prefer his lab drawn for that day. Resident #88 agreed to allow Phlebotomist to draw lab and lab was obtained on 7/30/14. Staff interviewed resident concerning lab draw preference and clarified with resident that he would allow Phlebotomist to draw his labs going forward. Care Plan was updated accordingly · Resident #114 -- MD and resident were notified on 8/21/14	08/30/2014

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	155271	A. BUILDING 00 B. WING	07/31/2014

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	order for valporic acid (lab to determine medication level), ammonia, ALT/AST (liver function test), and platelet levels/labs to be drawn every 6 months in January and July. The order was initiated on 8/16/13. A review of the (Name of Lab Company) report indicated the above labs were drawn on 12/3/13 and were attempted three times in June 2014. No other orders were located in the clinical record for these labs to be drawn in December or June. During an interview with Quality Assurance (QA) Nurse on 7/28/14 at 3:00 p.m., she indicated she was unsure why the labs were attempted in June when the orders were written for the labs to drawn in July. She further indicated Physician's Orders were expected to be followed as written. On 7/29/14, at 11:36 a.m., the Director of Nursing (DoN) indicated the facility was not able to locate any orders for the above labs to be drawn in December instead of January and in June, when the labs were ordered for July. The DoN further indicated Nursing Staff was supposed to follow Physician's Orders as written.		that three doses were missed Resident #114 suffered no ill effects from missed doses · Resident #154 no longer resides in facility **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents that have orders for daily weights, antibiotic therapy and lab draws have the potential to be affected by the alleged deficient practice · All residents with preferences regarding lab draws will be audited to ensure preferences are being honored and Care Plan is accurate · All residents on antibiotic therapy will be audited to ensure MD orders and Care Plan are being followed and any missed doses if found have appropriate MD and family/RP notification · All residents with orders for daily weights will be audited to ensure orders are being followed and if any are missed, MD and family/RP will be notified immediately · Licensed staff will be in-serviced by Director of Nursing or designee by August 30th, 2014	

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	1b. The July Physician's Orders for Resident #88 indicated an order for [Facility] Nursing Staff to draw blood specimens for all labs per resident preference and an order for valporic acid, ammonia, ALT/AST, and platelet levels to drawn every 6 months in January and July. Both orders was initiated on 8/16/13. The Physician's Orders further indicated an order for Hemoglobin A1C (lab to determine average blood glucose level) to drawn every 3 months (January, April, July, October). A review of the (Name of Lab Company) report indicated the above labs, except the hemoglobin A1C, were drawn on 12/3/13. The hemoglobin A1C was drawn on 1/2/14. Two (Name of Lab Company) reports, dated 6/5/14 and 7/28/14, indicated the resident refused all attempts by the lab phlebotomist (person that draws blood specimens) to obtain requested lab work [hemoglobin A1C, valproic acid, ALT/AST, ammonia, & platelets]. No attempts by Facility Staff for the ordered labs were located in the clinical record. The QA Nurse indicated on 7/28/14 at 3:00 p.m., the Nursing Staff should have followed Physician's Orders and drawn the above labs and not have had the		on New Orders – Verbal/Telephone (Medrec) Policy **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed staff will be in-serviced by Director of Nursing or designee by August 30th, 2014 on New Orders – Verbal/Telephone (Medrec) Policy · Nurse Management will review MAR/TAR and EHR daily to ensure ongoing compliance with following MD orders and Care Plan · Nurse Management will review lab tracker daily to ensure labs are obtained as ordered and per Care Plan **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Services by Qualified Persons QA tool will be completed weekly X 4 weeks, monthly X 3 months, and	

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	[Name of Lab] Phlebotomists attempt to draw the ordered labs On 7/29/14, at 11:36 a.m., the DoN indicated all the labs listed above in December, January, June, and July were drawn/attempted by [Name of Lab] staff and not [Facility] Nursing Staff as ordered by the Physician. The DoN further indicated there weren't any records of Facility Nursing Staff attempting/drawing the ordered labs. 2. The clinical record for Resident #114 was reviewed 07/25/14 at 1:40 p.m. The diagnoses for Resident #114 included, but were not limited to, dementia without behavioral disturbances, depression, hepatitis, and congestive heart failure. A Physician's Order, dated 6/18/14, indicated an order for Cleocin [antibiotic] 300 mg (milligrams) by mouth three times a day at 6 a.m., 2 p.m., and 10 p.m. for 7 days for a suspected mandibular (jaw) abscess/infection. The June MAR (Medication Administration Record) indicated Cleocin was not given on the following days: 6/19/14 at 10 p.m., 6/20/14 at 6 a.m., and 6/22/14 at 6 a.m.		quarterly thereafter results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·MAR/TAR Review QA tool will be completed weekly X 4 weeks, monthly X 3 months, and quarterly thereafter results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	

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	During an interview with the Quality Assurance (QA) Nurse, on 7/28/14 at 10:50 a.m., the QA Nurse indicated the Cleocin was not given on the dates and times listed above, according to the MAR. At 11:47 a.m., on 7/28/14, the QA Nurse indicated she was unable to locate any documentation that indicated the missed antibiotic doses above were given at any other times. The QA Nurse indicated Nursing Staff was expected to follow Physician's Orders as written. 3. The clinical record for Resident #154 was reviewed on 7/24/14 at 10:17 a.m. Resident #154 was admitted to the facility on 7/4/14. The diagnoses for Resident #154 included, but were not limited to, edema. The July, 2014 Physician's Orders for Resident #154 indicated, "DAILY WEIGHT-AFTER VOIDING AND BEFORE BRFST/MEDS (breakfast/medications) W/SAME (with same) CLOTHES EACH DAY DOCUMENT WT (weight) IN (name of database)" with a start date of 7/4/14. The orders also indicated, "NOTIFY MD OF 2 LB WT GAIN IN 1 DAY AND 4 LB WT GAIN IN 5 DAYS" with a start date of 7/4/14.			

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	The July, 2014 weights, from the facility database in which Resident #154's weights were ordered to be documented, were reviewed on 7/30/14 at 11:15 a.m. with the DON (Director of Nursing). There was a total of 3 daily weights entered...7/4/14, 7/7/14, and 7/19/14. The DON indicated, "If we're doing daily weights, they should be in (name of database.) I'll look to see if they are documenting them somewhere else." Regarding how the facility intended to notify the MD of a 2 pound weight gain in one day, as ordered, if daily weights were not done, she indicated, "I don't know how we could notify the MD of a weight gain, if we're not taking the daily weights." An interview was conducted with LPN #7 on 7/30/14 at 11:40 a.m. She indicated, "These are the only weights I have for her (Resident #154) for July (2014)." She provided a Daily Weights form for Resident #154 with daily weights from 7/7/14 to -7/13/14. LPN #7 stated, "This is all we have, and what's in (name of database.) No daily weights were provided or documented in the facility database for the following dates: 7/5/14, 7/6/14, 7/14/14 through 7/18/14, and 7/20/14			

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	through 7/29/14. 3.1-35(g)(2)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to implement care as ordered by a physician to prevent skin breakdown. This affected 1 of 3 residents reviewed for skin breakdown. (Resident #89) Findings include: Resident #89's record was reviewed on 7/24/14 at 11:22 a.m. The resident's diagnoses included, but were not limited to, diabetes type II, chronic kidney disease, hypertension, osteoarthritis, vascular dementia. The resident's medications included, but were not limited to, trazodone, lantus insulin, celexa, hydrochlorothiazide, and calmoseptine cream. On 7/28/14 at 10:43 a.m., during an observation of Resident #89's posterior	F000309	**F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #89 – MD was notified on 8/21/14 regarding Calmoseptine Cream treatment error. Cushion to wheelchair was upgraded on 7/30/14 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	08/30/2014

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	right thigh area along with LPN #1, there was a small open area, approximately dime sized, oblong, and pink to the right posterior thigh area of Resident #89. LPN identified the area as an "open area." LPN #1 indicated believing nursing staff already knew about the open area. On 7/29/14 at 10:18 a.m., during an observation of Resident #89's right posterior thigh area, along with LPN #1 and the DON, the DON indicated the area, identified in the paragraph above, to the right posterior thigh was open. The DON indicated the area, as a break in skin integrity, had the potential to become infected. On 7/29/14 at 11:12 a.m., during an interview, the DON indicated the open area to Resident #89's right posterior thigh should have been documented by nursing staff on 7/22/14, when she believed the nursing staff became aware of the right posterior thigh open area wound. On 7/29/14 at 2:07 p.m, during an interview, Unit Manager #2 indicated she would expect any nurse to notify the physician the same day that she identifies a new resident wound. She indicated not being made aware of Resident #89's right posterior thigh wound until 7/29/14 when		· All residents at risk for skin breakdown have the potential to be affected by the alleged deficient practice · Facility skin sweep will be conducted by August 30th, 2014. All impairments in skin integrity will be evaluated by a Licensed Nurse and reported to Physician for appropriate treatment and interventions · Licensed Nurses will be in-serviced by August 30th, 2014 by the Director of Nursing or designee on Skin Management Program **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed Nurses will be in-serviced by August 30th, 2014 by the Director of Nursing or designee on Skin Management Program · The Interdisciplinary Team will review all new admissions, re-admissions, physician orders and 24 hour report to identify residents with actual skin impairment for evaluation, intervention and monitoring ·Director of Nursing or designee will be alerted to all new skin alterations via the EHR	

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	the Wound Nurse Practitioner observed the wound. On 7/30/14 at 10:13 a.m., during an interview with the DON, she indicated Calmoseptine is a medication used to prevent skin breakdown. On 7/30/14 at 10:41 a.m., the Wound Nurse Practitioner indicated Calmoseptine is a skin cream used, in part, to prevent skin breakdown. He indicated if Calmoseptine was not applied to Resident #89's skin as ordered, it may have contributed to skin breakdown. The WNP indicated the wounds on Resident #89's posterior thighs were possibly from a "shearing" force. An MDS assessment, dated 7/22/14, indicated Resident #89 is at risk for skin breakdown. The same assessment indicated Resident #89 did not have any moisture associated skin damage. On 7/29/14 at 1:39 p.m., during an interview, the Wound Nurse Practitioner (WNP) indicated he observed Resident #89's posterior thigh on 7/29/14 at 1:30 p.m. He indicated observing two open areas to Resident #89's right posterior thigh area. The WNP indicated measuring one wound as 2.1 x 0.5 x		dashboard and the 24 hour report and will oversee that all assessment and documentation is completed · Skin sweeps will be held monthly and Director of Nursing or designee will ensure that appropriate evaluation, interventions and monitoring occur **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Skin Management QA tool will be completed weekly x 4 weeks, monthly x 3 months, and then quarterly for one year ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	

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	0.1cm (centimeters) to the right posterior thigh area of Resident #89. He indicated the wound was likely from a shearing force, possibly related to the resident's wheelchair. He indicated the wound was not present during his 7/22/14 assessment of Resident #89. He also indicated there were 2 small open areas, described by the WNP as "abrasions" to Resident #89's left posterior thigh area, which were also new since his 7/22/14 assessment of Resident #89. A wound assessment progress note, dated 7/29/14, indicated the "...initial wound encounter measurement..." for a right posterior leg wound was 2.1 cm (centimeter) length x 0.5 cm width x 0.1 cm depth. The wound was identified as an "...acute Full Thickness Trauma Wound..." A physician's order, dated 7/22/14, indicated for Resident #89 to receive calmoseptine lotion to the back of both of Resident #89's thighs as a "preventative" measure. Resident #89's medication and treatment administration records from July 22nd, 2014 through July 31st, 2014 indicated Resident #89 did not receive the protective skin barrier cream Calmoseptine.			

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	On 7/30/14 at 10:51 a.m., the DON indicated she could not find nursing documentation to show Calmoseptine cream as provided to Resident #89 as ordered. She indicated the medication and treatment administration records, after 7/22/14, for Resident #89 did not include the Calmoseptine cream. She indicated when a physician's order is written for a medication or skin treatment, the medication administration and treatment records should be updated with the new order. The DON indicated a resident's skin could breakdown if a skin barrier cream, such as Calmoseptine, was not applied to skin areas as ordered. 3.1-37(a)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident			

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	receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a non skid surface was maintained on a resident's recliner seat as directed by the care plan. This affected 1 of 3 residents reviewed for accidents. (Resident #89) Findings include: Resident #89's record was reviewed on 7/24/14 at 11:22 a.m. The resident's diagnoses included, but were not limited to, Diabetes type II, CKD, hypertension, osteoarthritis, vascular dementia. The resident's medications included, but were not limited to, trazodone, lantus insulin, celexa, hydrochlorothiazide. On 7/28/14 at 9:41 a.m., during an observation, Resident #89 was in her wheelchair in her bedroom. Next to her was her recliner, which did not have a non skid surface on the recliner seat. A nursing fall event progress note, dated 7/10/14, indicated Resident slid to the floor with assitance of an unidentified staff member. The note indicated resident was not injured in the fall. A care plan for fall risk included	F000323	**F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #89 -- Care Plan for falls was reviewed on 7/30/14. Upon noting a 'no-slip' surface was missing, it was immediately replaced **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents that reside in the facility and have a fall Care Plan with specific interventions have the potential to be affected by the alleged deficient practice ·All residents at risk for falls will be audited to ensure fall interventions are in place per Care Plan ·Staff will be in-serviced by the Director of Nursing or designee by August 30th, 2014 on Fall Management Procedure	08/30/2014

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	interventions for Resident #89 to use the call light when needing assistance to ambulate or transfer. It also included interventions for the resident to wear non-skid footwear, encourage resident to use assistive devices and handrails, apply non-skid surface to recliner seat, bed mat at bedside, low bed, quarterly risk assessment for fall risk. The care plan also indicated resident #89 transferred with two person assistance. A fall risk care plan, dated 7/23/13, indicated for staff to apply a non skid surface to Resident #89's recliner seat. On 7/30/14 at 1:56 p.m., during an interview, Occupational Therapy aide #20 indicated therapy staff would utilize a no slip product similar to Dysom to a recliner seat to prevent slipping or sliding out of a recliner. On 7/30/14 at 11:41 a.m., during an observation, Resident #89 was sitting in her recliner in her room. The recliner seat did not have a non skid surface on it. On 7/30/14 at 1:52 p.m., during an observation, Resident #89's recliner seat did not have a non skid surface on it. On 7/30/14 at 1:52 p.m., during an interview, CNA #3 indicated having		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Staff will be in-serviced by the Director of Nursing or designee by August 30th, 2014 on Fall Management Procedure ·Director of Nursing or designee will be alerted to all new incidents/accidents via the EHR dashboard and the 24 hour report and will oversee that all assessment and documentation is completed ·Nurse Management and Interdisciplinary Team will review any falls daily and update the plan of care each time there is a change in intervention and communicate to staff **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Fall/Accident QA tool will be utilized weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting	

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MILLER'S SENIOR LIVING COMMUNITY	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

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	frequently worked with Resident #89 in the past and not recalling a non skid type product, such as Dysom, on Resident #89's recliner seat. On 7/30/14 at 2:18 p.m., during an interview, the facility nurse consultant indicated resident's care plans should be followed at all times. On 7/30/14 at 2:27 p.m., during an interview, the DON indicated the non skid type product should have been on Resident #89's recliner seat as care planned. 3.1-45(a)(2)		overseen by the Executive Director	
F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed to	F000325	**F325 MAINTAIN NUTRIONAL STATUS UNLESS**	08/30/2014

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	provide a resident super pudding as care planned and follow a Physician's Order/Dietary Recommedation for 2 of 4 residents reviewed of 8 who met the criteria for nutrition. (Resident #128 & 104) Findings include: 1. The clinical record for Resident #128 was reviewed on 7/29/14 at 11:30 a.m. The diagnoses for Resident #128 included, but were not limited to, malnutrition. The 5/21/14 Quarterly Dietary Assessment for Resident #128 indicated he was malnourished, and had a body mass index of 20.8. The 2/27/14 nutrition care plan, reviewed 5/15/14, indicated an intervention was, "Serve super pudding at lunch and supper." An observation of Resident #128 eating lunch in the dining room was made on 7/29/14 from 12:25 p.m. to 1:00 p.m. No pudding was observed at his table. At 12:55 p.m., CNA #8 assisted Resident #128 out of the dining room. An interview was conducted in the dining room with CNA #9 on 7/29/14 at 12:57		**UNAVOIDABLE** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #128 – Dietary Manager was informed on 7/29/14 that resident did not receive supplement as recommended. CNA assisting resident with meal was immediately educated on reading and following meal ticket. Dietary staff was educated immediately on following meal ticket · Resident #104 – On 8/21/14, resident's MD was notified regarding resident receiving food items outside of therapeutic diet order. Resident #104 suffered no ill affects from consuming food outside of therapeutic diet order **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents with recommended dietary supplements and with specialized renal diet orders have the potential to be affected by the alleged deficient practice · Staff will be in-serviced by	

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	p.m. She walked over to the table at which Resident #128 was previously sitting, and stated, "No, he didnt get the super pudding. It should have come with his tray." An interview was conducted with the DM (Dietary Manager) on 7/29/14 at 1:00 p.m. regarding whether Resident #128 received super pudding with his lunch. She indicated, "I guess we forgot. Normally, it would come out with his meal." The 7/29/14 lunch ticket for Resident #128 indicated, "DM: Super Pudding - 8 Sc." 2. The clinical record for Resident #104 was reviewed 07/29/14 at 2:45 p.m. The diagnoses for Resident #104 included, but were not limited to, end stage renal disease, diabetes mellitus, and hemorrhage of gastrointestinal tract. The July Physician's Orders indicated a diet of 3-4 grams of sodium and a renal diet which included, no oj (orange juice), bananas, tomato juice, 1 serving or less of potatoes, and 1 cup of milk or less. During an observation of Resident #104's lunch tray, on 7/31/14 at 1:05 p.m., a banana peel was noted on the tray.		Director of Nursing or designee by August 30th, 2014 on following meal ticket specifications as it relates to dietary supplements and specialized renal diets **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff will be in-serviced by Director of Nursing or designee by August 30th, 2014 on following meal ticket specifications as it relates to dietary supplements and specialized renal diets ·Dietary Manager or designee will observe a minimum of two meals daily to ensure compliance with meal ticket specifications with a special emphasis on supplements and renal diets ·Director of Nursing or designee will make walking round through dining room at least once daily and check meal tickets to ensure compliance and educate staff as needed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Dietary Services QA tool will be utilized weekly x 4 weeks,	

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	During an interview with Resident #104, on 7/31/14 at 1:06 p.m., Resident #104 indicated he had a sandwich, banana, and oatmeal cookie for lunch. Resident #104's Dietary Meal Ticket, on his meal tray, indicated, "No O.J., Banana,...." The statement was highlighted. The Annual MDS (minimum data set) Assessment, dated 4/12/14, indicated a BIMS (brief interview of mental status) score of 12, which was indicative moderatively impaired cognition and interviewable. On 7/30/14, at 1:20 p.m. the Dietary Manager indicated Resident #104 doesn't always follow dietary recommendations and the facility "care planned" this. A review of a Nutritional Care Plan, dated 5/12/14, indicated "...Resident continues to choose food items outside of recommended items according to diet...." The Care Plan indicated an intervention of, "...serve diet as ordered...No oj [sic], banana's [sic].... At 1:25 p.m., on 7/30/14, Resident #104 indicated the Dietary Staff just brought him the banana and he didn't ask for it.		monthly x 3 months, and quarterly thereafter for one year. Data will be submitted to the QA Committee overseen by the Executive Director for follow up. ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	

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	3.1-46(a)(2)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to recognize a medication allergy that could have had an adverse consequence, for 1 of 6 residents	F000329	**F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** **What corrective action(s) will**	08/30/2014

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	reviewed for unnecessary medications (Resident #114). Findings include: The clinical record for Resident #114 was reviewed 07/25/14 at 1:40 p.m. The diagnoses for Resident #114 included, but were not limited to, dementia without behavioral disturbances, depression, hepatitis, and congestive heart failure. Resident #114 was admitted to the facility on 6/6/14. A review of the [Name of Hospital] Discharge Summary, printed on 6/6/14, indicated an allergy to Trazodone (depression/sleep medication) due to rash and behavioral changes. An Physician Admission Note/Progress Note, dated 6/9/14, indicated an allergy to Trazodone. A Progress Note, dated 6/12/14, indicated, "Writer spoke to [Name of Nurse Practioncer] on call for [Name of Medical Doctor] [symbol for at] 2420am [sic-12:20 a.m.] and verbalized daughter [sic] concern and that pt [patient] continues to be restless and not able to fall asleep. Writer received a new order for Trazadone [sic] 50 mg [sic-milligrams] [symbol for times] 1		**be accomplished for those residents found to have been affected by the deficient practice?** · Resident #114 – Allergy to Trazodone was discontinued on 7/25/14 and MD indicated that this is not a true allergy **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents residing in the facility that have noted allergies have the potential to be affected by the alleged deficient practice · All residents with noted allergies will be audited to ensure medications causing allergies to that particular resident are not ordered and/or given · Licensed Nurses will be in-serviced by Director of Nursing or designee by August 30th, 2014 on Medication Administration Policy as it relates to checking for allergies prior to medication administration **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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	now. Med [Medication] pulled from Pixes [sic-medication dispenser] and adm [administered] at 2430am [sic-12:30 a.m.] per MD [Medical Doctor] orders. MAR [Medication Administration Record] updated." The MAR for Resident #114 indicated the Resident received Trazodone 50 mg on 6/12/14. During an interview with the Director of Nursing (DoN), on 7/25/14 at 1:53 p.m., the DoN indicated the Trazodone should not have been administered to the Resident when there was documentation indicating the Resident was allergic to the medication. 3.1-48(c)(2)		· Licensed Nurses will be in-serviced by Director of Nursing or designee by August 30th, 2014 on Medication Administration Policy as it relates to checking for allergies prior to medication administration ·Director of Nursing and/or designee will complete MAR/TAR audits daily to ensure that residents with allergies do not have an order for or are not being administered medications with a known allergy **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · MAR/TAR Review QA tool will be utilized weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	
F000406	483.45(a)			

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SS=D	PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on interview and record review, the facility failed to provide a Speech Therapy screen in a timely manner for a resident who indicated they felt like food was stuck in their throat. This affected 1 of 3 residents reviewed for rehabilition (Resident #71). Findings include: The clinical record for Resident #71 was reviewed 07/28/14 at 2:15 p.m. The diagnoses for Resident #71 included, but were not limited to, esophageal strictures, anemia, and benign prostatic hyperplasia. A Progress Note, dated 5/6/14, indicated, "...Writer spoke with patient regarding his weight loss and lack of intake. Patient reported that he is limited on his intake due to the pain he experiences with swallowing secondary to his esophageal strictures...."	F000406	**F406 PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #71 – On 8/7/14 Care Plan meeting was held with resident and POA to address therapy screen related to Esophageal Stricture. Resident communicated that he did not wish to have any further treatment done to address the stricture. POA in agreement with plan · Resident #71 no longer resides in facility **How will you identify other**	08/30/2014

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	A Progress Note, dated 5/7/14, indicated, "residents [sic] diet was changed to a pureed texture upon his request....Resident has pain when swallowing foods and liquids in [sic] r/t [related to] esophageal strictures....' A Progress Note, dated 6/12/14, indicated, "...he struggles to eat because he feels like the food is stuck in his throat and he doesn't feel as if it does down correctly. Resident is not eating/drinking appropriately. Resident does have a hx [history] of esophogeal [sic] strictures. Will ask speech to screen." The Clinical Record did not indicate a Speech Therapy screen was done until 7/14/14. During an interview with the Therapy Manager, on 7/29/14 at 9:55 a.m., the Therapy Manager indicated she will look at Resident #71's records to determine his Therapy course. At 10:13 a.m., on 7/29/14, the Administrator indicated she was unsure why it took over a month to do the Speech Therapy Screen, but she and Therapy will further look into it. The Administrator indicated, on 7/29/14		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who reside in facility and have difficulty swallowing have the potential to be affected by the alleged deficient practice · All residents and/or responsible parties [where applicable] will be interviewed utilizing section: Oral Health of QIS interview; Interdisciplinary Team will ensure timely and appropriate follow up if swallowing difficulty is indicated ·Staff will be in-serviced by Director of Nursing or designee by August 30th, 2014 on 'Nursing Assessment of Patient Function' therapy communication tool **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Staff will be in-serviced by Director of Nursing or designee by August 30th, 2014 on 'Nursing Assessment of Patient Function' therapy communication tool	

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	at 10:58 a.m., the "Regional Office" was looking at their Therapy notes to determine why the Screen took over a month to complete. On 7/30/14 at 9:40 a.m., the Administrator indicated the Facility and Therapy were not able to locate any documentation related to the delay for a Speech Therapy screen for difficulty swallowing. The Administrator further indicated she was unsure why the therapy screen took over a month to complete, but the therapy screen should've been done in a more timely manner. 3.1-23(a)(1)		· Therapy Department to provide Director of Nursing with copies of 'Nursing Assessment of Patient Function' communication forms daily. Interdisciplinary Team will review communication forms to ensure appropriate follow up is completed and documented accordingly ·The Interdisciplinary Team will meet to review which services need to be obtained and update plan of care accordingly **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Specialized Rehab Services Review QA tool will be utilized weekly X 4 weeks, monthly x 3 months, and quarterly thereafter for one year ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	
F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance			

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	with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview, and record review, the facility failed to follow through with a dental treatment plan for 1 of 1 resident reviewed of 1 who met the criteria for dental status and services, and 1 of 1 resident reviewed for Pre Admission Screening and Resident Review. (Residents #33 and #96) Findings include: 1. The clinical record for Resident #33 was reviewed on 7/24/14 at 10:30 a.m. The diagnoses for Resident #33 included, but were not limited to, edentulous. An interview was conducted with Resident #33's husband, Family Member #12, on 7/24/14 at 11:04 a.m. Regarding whether Resident #33 had any denture, chewing, or eating problems, he indicated, "She can't chew like she needs to, and has lost weight." The 5/7/14 Quarterly Nutrition Assessment for Resident #33 indicated she had a weight change of more than	F000412	**F412 ROUTINE/EMERGENCY DENTAL SERVICES** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #33 was evaluated by Dentist on 8/6/14. Resident agreed to new set of dentures ·Resident #96 was evaluated by Dentist on 7/31/14 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents who require and/or request dental services have the potential to be affected by the alleged deficient practice · All residents and/or responsible parties [where applicable] will be interviewed utilizing section: Oral Health of	08/30/2014

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	10% over the last 180 days. The 7/16/14 dental care plan for Resident #33 indicated, "Potential for oral/dental problems related to: Patient is edentulous and wears full set of top and bottom dentures. Refer to dentist/hygienist for evaluation/recommendations re (regarding): denture realignment or new fitting dentures." An interview was conducted with Family Member #12 on 7/28/14 at 10:51 a.m. He indicated, "She wears her dentures, but since she's lost weight, the dentures don't fit anymore. I think she needs to get them refit, so she can chew her food. They slide around. No one has ever said anything to me about getting them refit. They had a dentist come in, and he saw her a few months ago. He checked them, but there was no follow up. They weren't fitting her then. I would think, if her dentures fit her properly, she could eat more....There's things she should be able to eat and can't eat, like ground sausage. They do grind it up, but she still can't eat it....It's been like this for quite some time, at least 3 or 4 months." The 3/5/14 Dental Exam Summary for Resident #33 indicated, "Pt (patient) seen per request, pt indicates slight		QIS interview; Interdisciplinary Team will ensure timely and appropriate follow up if dental issues are indicated ·Staff will be in-serviced by Director of Nursing or designee by August 30th, 2014 on Dental Services Policy **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Staff will be in-serviced by Director of Nursing or designee by August 30th, 2014 on Dental Services Policy ·Social Services Director or designee will review the results of the monthly QIS interviews to make appropriate referrals to the dentist of the resident's choice ·Interdisciplinary Team will review resident dental referrals and visits to ensure there is appropriate follow-up **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Dental Status and Services Review QA tool will be utilized	

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	generalized discomfort with dentures. Biotene oral swabs perscribed (sic) 11/2013. Staff says pt is receiving oral lubricant and has been wearing her dentures at meals. No sore spots visible today. Rec'd (Recommend) continue with oral swabs for dry mouth. Evaluate pt in 2 weeks for persisting soreness. If general health and stamina is improved, consider for new c/c (complete/complete - maxillary denture over mandibular denture)....Treatment plan: Schedule 2 weeks -14 days follow up." No information was found in Resident #33's clinical record to indicate a 2 week follow up was done as per the 3/5/14 dental treatment plan. An interview was conducted with the DON (Director of Nursing) on 7/28/14 at 12:13 p.m., regarding whether there was a 2 week follow up, or whether a new set of dentures was considered after the 3/5/14 dental exam. She indicated she did not see anywhere that the 2 week follow was done, or anything to suggest a new set of dentures was considered, reviewed, or discussed. She indicated, "What we could do moving forward, is have (name of dental company) come back in and reevaluate her." Another interview was conducted with		weekly X 4 weeks, monthly x 3 months, and quarterly thereafter for one year ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	

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	the DON on 7/28/14 at 12:48 p.m. She indicated, "I spoke with her husband....He referenced her needing new dentures, because the ones she has are stopping her from eating. I called (name of dental company), and we have her scheduled for 8/6 (8/6/14) at 9 a.m. for a molding." An interview was conducted with the Administrator on 7/31/14 at 9:45 a.m. She indicated, "It looks like she refused (dentures) back in November, 2013. I don't have any verification of refusals after 3/5 (3/5/14 dental exam). She's going to be seen 8/6 (8/6/14)." 2. The clinical record for Resident #96 was reviewed on 7/30/14 at 1:30 p.m. The diagnoses for Resident #96 included, but were not limited to, mild intellectual disability. The 6/26/14 Pre-Admission Screening/Annual Review Certification For Nursing Facility Services (PASSR) Level 2 was reviewed. A recommendation indicated was, "(Name of Resident #96) may benefit from assistance to insure (sic) routine optometry, audiology, dental, and medical follow along, as well as specialized medical follow along when indicated."			

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	The 3/5/14 Dental Exam Summary indicated, "Pt (patient) present initial exam 3/5/14, no chart available...lateral pink ulcer present with white border pt (patient) indicates she bit her tongue suspect traumatic ulcer, 2 week f/u (follow up) and possible prophy (prophylaxis) if chart available....Treatment Plan: Schedule: 2 weeks - 14 days prophy. Schedule: 2 weeks - 14 days referral follow up Notes: f/u ulcer left lingual." An interview was conducted with CNA #11 on 7/30/14 at 2:13 p.m. She indicated, "I don't see where the prophy was done 2 weeks later, or the follow up ulcer left lingual. I'll call (name of dental company.)" CNA #11 called the dental company, and left a voicemail requesting a return call. On 7/31/14 at 9:45 a.m., the Administrator provided a note faxed to CNA #11 of the Social Services Department from the dental company. It indicated, "On March 5th 2014, (name of Resident #96) was seen by the dentist and treatment planned to be seen again in 2 weeks for a follow up. (Name of dental company) was in on the following dates: 3/12, 3/20, 3/27, 3/31, 4/9, 4/17, 5/5, 5/9. On March 13th, we were informed (name of Resident #96) was in the hospital and			

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	may not be available for the visit on 3/20 (3/20/14). On March 27th 2014, our team came in for a delivery and noted that (name of Resident #96) was still not feeling well after a return from hospital...." On 7/31/14 at 9:45 a.m., the Administrator provided a list of dates of hospital stays for Resident #96. The dates were as follows: 3/13 - 3/17, 3/19 - 3/25, 4/1 - 4/5, 4/19 - 5/15, and 5/26 - 5/30. It was pointed out the the Administrator that the dentist was in the facility on 3/31/14, 4/9/14, and 4/17/14, all dates when Resident #96 was also in the facility, and not at the hospital. The Administrator agreed. 3.1-24(a)(1)			
F000425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure			

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	the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to have an antibiotic available for administration. This affected 1 of 6 residents reviewed for unnecessary medication (Resident #114). Findings include: The clinical record for Resident #114 was reviewed 07/25/14 at 1:40 p.m. The diagnoses for Resident #114 included, but were not limited to, dementia without behavioral disturbances, depression, hepatitis, and congestive heart failure. A Physician's Order, dated 6/18/14, indicated an order for Cleocin (antibiotic) 300 mg (milligrams) by mouth three times a day at 6 a.m., 2 p.m., and 10 p.m. for 7 days for a suspected mandibular (jaw) abscess/infection. The June MAR (Medication Administration Record) indicated Cleocin was not given on the following days as ordered: 6/19/14 at 10 p.m.,	F000425	**F425 PHARMACEAUTICAL SVC-ACCURATE PROCEDURES, RPH** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #114 -- MD and resident were notified on 8/20/14 that three doses were missed. Resident #114 suffered no ill effects from missed doses **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents on antibiotic therapy have the potential to be affected by the alleged deficient practice · Residents who have had an order for antibiotic therapy within the last 30 days will be	08/30/2014

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	6/20/14 at 6 a.m., and 6/22/14 at 6 a.m. The MAR further indicated Cleocin was not available in the Facility on 6/19/14 and 6/20/14. During an interview with the Quality Assurance (QA) Nurse, on 7/28/14 at 10:50 a.m., the QA Nurse indicated the Cleocin was not given on the dates and times listed above because the medication was not in the Facility, according to the MAR. At 11:47 a.m., on 7/28/14, the QA Nurse indicated if the above medication was not available at the Facility, as the MAR indicated, the nurse should have called the Pharmacy. The QA Nurse further indicated she was unable to locate documentation that the medication was in the facility. A policy titled, Emergency Pharmacy Service and Emergency Kits, dated 4/14/14, was received from the QA Nurse, on 7/28/14 at 1:30 p.m. The policy indicated, "...4. If the medication is not available, calls [sic] and faxes [sic] the pharmacy, using the after-hours emergency numbers if necessary...." 3.1-25(a)		audited to ensure doses have been administered as ordered · Licensed Nurses will be in-serviced on Emergency Pharmacy Service and Emergency Kits by the Director of Nursing or designee by August 30th, 2014 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed Nurses will be in-serviced on Emergency Pharmacy Service and Emergency Kits by the Director of Nursing or designee by August 30th, 2014 · Residents currently on antibiotic therapy will be monitored daily by nurse management or designee reviewing MAR/TAR to ensure doses are not missed and/or proper MD notification occurs **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Medication Availability QA tool will be utilized weekly X 4 weeks, monthly X 3 months, and quarterly thereafter to ensure medications are available as	

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			ordered ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash			

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	their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure appropriate linen storage to prevent potential spread of infection. This had the potential to affect 17 residents who used linen from the downstairs linen room of 76 residents in the facility. The facility also failed to ensure a resident with a clostridium difficile (C-diff) infection was provided a separate room for infection control purposes according to facility policy. This had the potential to affect 1 resident residing with the Resident with the active infection. (Resident #46) Findings include: 1. An initial tour of the facility was conducted on 7/23/14 at 11:08 a.m. The downstairs linen room was observed with several pairs of used latex gloves laying on the floor in the middle of the room, on the floor in the corner of the room, and on a plastic bag full of clean linen. One clean towel, one clean wash	F000441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Linen closet was immediately cleaned and linens and trash found on floor immediately removed · Resident #100 – Isolation was discontinued on 7/28/14 per MD order **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who reside in this facility have the potential to be affected by the alleged deficient practice · All residents with current orders for isolation will be reviewed to ensure a private room has been offered if available	08/30/2014

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	cloth, and 4 clean sheets were observed on the floor. Three clean briefs were on the floor. The floor was dirty. There were cob webs on the linen racks just below clean linens. An observation of the linen room was made with Housekeeping/Laundry Staff Member #13 on 7/23/14 at 11:15 a.m. She indicated there was at least 4 sheets on the ground and 4 used latex gloves. She picked up 4 of the used gloves. She indicated she saw the cobwebs below the sheets on the linen racks. She stated, "I haven't been in here today. There's at least 5 clean briefs on the floor and an empty toothpaste box....It's everyone's responsibility to keep this room clean, including the CNA's (Certified Nursing Assistants) who use it." An observation of the linen room was made with the Housekeeping Manager on 7/23/14 at 11:34 a.m. She stated, "It looks like they're using this room as a trash can. This isn't the first time this has happened. I've personally spent a lot of time cleaning this room up. I see the pair of dirty gloves on the floor in the corner. I don't know if this is an infection control issue, but I know it shouldn't look like this." The Linen Handling policy from the		· Staff will be in-serviced by Director of Nursing or designee by August 30th, 2014 on Linen Handling and Clostridium Difficile Policy and Procedure **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff will be in-serviced by Director of Nursing or designee by August 30th, 2014 on Linen Handling and Clostridium Difficile Policy and Procedure · The Interdisciplinary Team will review physician orders and 24 hour report in clinical meeting to identify residents with signs and symptoms requiring isolation, positive lab results, and diagnosed infections to ensure proper infection control practices are initiated and maintained ·Director of Nursing or designee will conduct daily rounds on all shifts to ensure infection control practices are being followed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Infection Control Review	

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	Infection Control Manual was provided by the Administrator on 7/23/14 at 1:50 p.m. It indicated, "Linens and laundry are handled or transported in a manner to prevent the spread of infection and/or contamination." 2. On 7/23/14 at 2:13 p.m., during an observation, Resident #100's room was observed with a sign on the outside of the door advising persons who would enter the room to check with nursing staff prior to entering the room. The room had two resident's beds. Resident #100's roommate (Resident #46) was observed in his bed which was less than 6 feet from Resident 100's bed. Yellow isolation gowns were observed inside the room, but no red biohazard bags were present in the room's linen or trash cans. There was one bathroom in the bedroom with one toilet. No commode was observed in the bedroom. On 7/23/14 at 2:27 p.m., during an interview, RN #3 indicated there were no red biohazard bags in Resident #100's room at the time. She indicated nursing staff would have to leave Resident #100's room to get a red biohazard bag to dispose of items contaminated with infectious material. She indicated the red biohazard bags should be kept inside Resident #100's room. She indicated Resident #100 was being treated for an		QA tool will be utilized weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	

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	active infection of clostridium difficile (C Diff). On 7/24/14 at 1:52 p.m, Resident #100 was observed in his room lying in his bed. His roommate was also in the room lying in his bed near the window. On 7/28/14 at 2:19 p.m., Resident #100 was observed in his room in his wheelchair. His roommate was observed lying on his bed near the window. A physician's order, dated 7/6/14, indicated for Resident #100 to have a stool sample collected to rule out a C Diff infection. The order also indicated for nursing staff to "...Initiate contact isolation..." A lab record, identifying a "reported date" of 7/9/14, indicated Resident #100 tested positive for C Diff. A physician's order, dated 7/10/14, indicated for Resident #100 to begin receiving Flagyl (an antibiotic medication) "...for C-DIFF..." On 7/31/14 at 11:02 a.m., the Nurse Consultant indicated the facility was not following current CDC guidelines, related to resident's with active C Diff infections, regarding sharing a room with			

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	a roommate who does not have a similar active infection. A facility policy titled "CLOSTRIDIUM DIFFICILE" was received from the DON on 7/31/14 at 11:01 a.m. Under Section F "...Treatment..." the policy indicated for resident's being treated for C Diff infections to "...Initiate Contact precautions..." and "...Place patient in private room if available..." On 7/31/14 at 11:11 a.m., the Administrator indicated Resident #100 could have, and should have, been placed in a private room when the resident was diagnosed with clostridium difficile, which occurred on 7/10/14. She indicated a private room was available for Resident #100 at the time he was diagnosed with the C Diff infection. 3.1-18(b)(2)			
F009999	State Findings 3.1-14 PERSONNEL	F009999	**F9999 FINAL OBSERVATIONS – State Findings – PERSONNEL**	08/30/2014

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	(b) A facility must not use any individual working in the facility as a nurse aide for more than four (4) months on a full-time, part-time, temporary, per diem, or other basis unless that individual: (1) is competent to provide nursing and nursing related services, and: (2) has completed a: (A) training and competency evaluation program; or (B) competency evaluation program approved by the division. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a CNA (Certified Nursing Assistant) received Indiana certification within 120 days of hire date for 1 of 33 CNA's reviewed for appropriate certification. (CNA #20) Findings include: The Employee Records form and CNA certifications were reviewd on 7/31/14 at 11:00 a.m. CNA #20 had a start date of 2/20/14. Upon review of CNA certifications, no Indiana nurse aide certification was found for CNA #20. An interview was conducted with the		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · All employee files will be audited to ensure licenses and certifications are up to date and on file. Any employee identified as having an expired license or certification will be removed from the schedule until appropriate licensure or certification is obtained · All employee files will be audited to check for 1st step and 2nd step ppds being placed and read as per policy. Those found without will have them placed and read **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who reside in this facility have the potential to be affected by the alleged deficient practice · All employee files will be audited to ensure licenses and certifications are up to date and on file. Any employee identified	

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	155271	A. BUILDING 00 B. WING	07/31/2014

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	Administrator and DON (Director of Nursing) on 7/31/14 at 12:15 p.m. The Administrator provided a print out from the Illinois Department of Public Health Worker Registry for CNA #20. The DON indicated CNA #20 was past his 120 days to receive his Indiana certification.3.1-14 Personnel (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method. (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a current employee had any documented tuberculin		as having an expired license or certification will be removed from the schedule until appropriate licensure or certification is obtained · All employee files will be audited to check for 1st step and 2nd step ppds being placed and read as per policy. Those found without will have them placed and read · HR Staff and In-Service Director or designee will be in-serviced by Executive Director or designee by August 30th, 2014 on Employee Health – TB Screening **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · HR Staff and In-Service Director or designee will be in-serviced by Executive Director or designee by August 30th, 2014 on Employee Health – TB Screening · HR Staff will be responsible for auditing and ensuring licenses are current and on file upon hire · In-Service Director will be	

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	skin testing done prior to working. The facility also failed to complete second step tuberculin skin testing for 3 of 5 current employees reviewed for two step tuberculin skin testing. This had the potential to affect 76 residents residing in the facility. Findings include: The following employee files were reviewed on 7/31/14 at 11:00 a.m.: Office Manager, Laundry Aide #15, Assistant Dietary Manager, and CNA #17. The employee record for the Office Manager did not include documentation that a second step tuberculin skin test was completed. The Office Manager's start date was 6/11/14. The employee record for Laundry Aide #15, did not include documentation that Laundry Aide #15 received any tuberculin skin testing. Laundry Aide #15's start date was 6/27/14. The employee record for Assistant Dietary Manager did not include documentation that a second step tuberculin skin test was completed. The Assistant Dietary Manager's start date		responsible for ensuring 1st step ppds are placed and read prior to hire and follow up to ensure 2nd steps are placed and read 7-21 days from a negative first step **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Human Resources Review QA tool will be utilized weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director	

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	was 5/14/14. The employee record for CNA #17 did not include documentation that a second step tuberculin skin test was completed. CNA #17's start date was 5/14/14. During an interview with the Director of Nursing, on 7/31/14 at 11:23 a.m., she indicated all employees should have tuberculin skin testing done and the two step method should be used. On 7/31/14, at 11:51 a.m., the Administrator indicated the Facility was unable to locate any documentation that any tuberculin skin testing was done for Laundry Aide #15 and the Administrator further indicated the Facility was unable to locate any documentation that the second step tuberculin skin testing was done for the above employees. A policy, titled Employee Health-TB Screening, dated 2/1/13, was received from the Administrator on 7/31/14 at 12:02 p.m. The policy indicated, "...E. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12)months [sic], the baseline tuberculin skin test should employ the two-step method. F. If the first [sic] is negative, a second step should be performed one			

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	(1)to [sic] three(3) [sic] weeks after the first step...."			